

DEPARTMENT OF HEALTH AND FAMILY SERVICES  
Division of Disability and Elder Services  
DDE-5644 (11/05)

STATE OF WISCONSIN

## INITIAL ENTRANCE SCREENING

Name - Inmate / Patient (Last, First, MI) <i>Miller Jesse</i>		ID Number <i>462433</i>	Facility Transferred From <i>DCI</i>	Birthdate <i>12-3-87</i>	Date - Admission <i>6-19-08</i>	Unit
TPR <i>96.7 90 16</i>	BP <i>112/74</i>	HT. <i>6' 1"</i>	Wt. <i>152</i>	Physician <i>Dr. Michowski</i>		
Heart <i>80 r</i>	Lung <i>clear</i>	Diagnosis <i>schiz affective disorder</i>				
ALLERGIES (Describe Agent and Reaction. Food, Medication, Other.) <i>Take cyclophosphamide Naloxone</i>						
LANGUAGE BARRIERS / LEARNING DEFICITS		SMOKER <input type="checkbox"/> Yes <input type="checkbox"/> No Packs per Day		EXERCISE <input type="checkbox"/> Yes <input type="checkbox"/> No Type		Frequency
MEDICAL TREATMENT (Hospitalizations and Operations, include Psychiatric and/or AODA Treatment)						
HOSPITAL LOCATION <i>4th day ago</i>		REASON / DIAGNOSIS			DATE ADMITTED	
CURRENT MEDICATIONS - INCLUDE PSYCHIATRIC, AODA AND OTHER MEDICATIONS <i>see medication transfer record</i>						
STREET DRUGS - TYPE		AMOUNT	FREQUENCY	DATE OF LAST USE	USE OF NEEDLES <input type="checkbox"/> Yes <input type="checkbox"/> No	
ALCOHOL USE - TYPE		AMOUNT	FREQUENCY	DATE OF LAST USE		
PAST SERIOUS INFECTIOUS DISEASE (If more space is needed use progress notes) <i>HBV ABC 0 STD 0 TB 0 2 2 8. dx HZV 0</i>						
MENTAL HEALTH						
Have you ever thought seriously about suicide? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was the last time?		Have you ever been on psychiatric medications in the past? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No When?				
Have you ever attempted suicide? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was the last time?		Do you currently hear voices or see visions? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>currently clearly hearing / and also sometimes experience visual hallucinations</i>				
Do you feel like hurting yourself now? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		VISIBLE SIGNS / OBSERVATIONS				
Expresses/appears depressed, agitated, anxious or hopeless <i>feeling more agitated</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No		Difficulty breathing <i>in position</i>		
Expresses extreme shame about crime <i>in prison</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No		Evidence of trauma (bleeding, abrasions, contusions)		
Verbally incoherent or makes no sense <i>can't talk</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No		Evidence of lesions, open wounds		
Does not know place, time, or name <i>in prison</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No		Difficulty in movement		
Signs of inappropriate behavior		<input type="checkbox"/> Yes <input type="checkbox"/> No		Signs of lice or scabies		
Lethargic		<input type="checkbox"/> Yes <input type="checkbox"/> No		Appears under the influence of drugs or alcohol		
Recent communicable illness symptoms, (e.g. chronic cough, coughing, coughing up blood, lethargy, weakness, weight loss, loss of appetite, fever, night sweats).		<input type="checkbox"/> Yes <input type="checkbox"/> No		Symptoms of drug/alcohol withdrawal		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		Abnormal appearance (e.g. sweating, tremors, disheveled)		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

COMMENTS: Explain any "Yes" answers above. (If more space is needed use progress notes)

*Most severe attempt at suicide - tried shoot around neck 4th day ago. Was at the hospital for a couple of hours. Currently clearly SZ. No voices. Ryma did better. Sleeps a little bit - but not = voices. Ryma did better. 240 mg. In prison 14 days First incarceration. Previous admission to WMAH*

DISPOSITION FOLLOW-UP:

☐ Needs Dental Appt ☐ Needs Chronic Disease Appt  
☐ Emergency Room

LIVING ARRANGEMENTS:

☐ General Population  
☐ Isolation for Communicable Disease

NURSE SIGNATURE &amp; TITLE

DATE COMPLETED

TIME

EXHIBIT

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